

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF AMBULANCE CLAIMS  
SUBMITTED BY EASTERN SHORE  
AMBULANCE SERVICE  
INCORPORATED**



**AUGUST 2001  
A-03-01-00001**



**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
**OFFICE OF INSPECTOR GENERAL**  
**OFFICE OF AUDIT SERVICES**  
**150 S. INDEPENDENCE MALL WEST**  
**SUITE 316**  
**PHILADELPHIA, PENNSYLVANIA 19106-3499**

August 20, 2001

Our Reference: Common Identification Number A-03-01-00001

Beth Brady, Director  
Medicare Benefits and Integrity Unit  
TrailBlazer Health Enterprises  
Executive Plaza III  
11350 McCormick Road  
Hunt Valley, Maryland 21031

Dear Ms. Brady:

This final report presents the results of our REVIEW OF AMBULANCE CLAIMS SUBMITTED BY EASTERN SHORE AMBULANCE SERVICE INCORPORATED (ESAI), located in Sanford, Virginia. Our review was conducted at the request of TrailBlazer Health Enterprises, LLC, the Medicare Part B Carrier (Carrier). The objective of our review was to determine the allowability and reasonableness of ambulance claims submitted for Medicare reimbursement by ESAI. Our review covered the period July 1, 1999 through June 30, 2000. During this period ESAI was reimbursed \$226,199.

We determined that \$110,417 of the \$226,199 reviewed was unallowable. Based on the results of a statistical sample, we found that at least \$108,439 of the non-emergency Basic Life Support (BLS) and Advanced Life Support (ALS) transports and related paid claims were unallowable. Of the 100 sample items reviewed: a) 38 sampled items were not medically necessary, and b) 22 sampled items were billed as ALS services, a level of service that ESAI was not equipped to provide. We also determined that all 15 emergency ALS and 5 emergency BLS paid claims totaling \$1,978 were not allowable. We are recommending that the Carrier: (1) recover overpayments totaling \$110,417; (2) provide increased training to ESAI regarding billing for ambulance services; and (3) consider placing ESAI on prepayment monitoring to ensure claims billed to Medicare are properly documented.

In response to our draft report, ESAI did not fully agree with our findings and recommendations. The ESAI requested that only \$16,592 be recovered as overpayments due to the additional information provided in their response. The ESAI also believed that no action should be taken to have the Carrier provide training or implement prepayment monitoring. The ESAI further stated that they made some mistakes in the past, have now taken all necessary steps to correct these mistakes, and will submit only clean claims in the future. The ESAI's comments to our draft

report are included as Appendix C. We summarized ESAI's comments along with our response to those comments in the Conclusion and Recommendations section of this report. Modifications were made in the final report based on ESAI's comments.

## **BACKGROUND**

In order for an ambulance service to be reimbursed by Medicare, it must be medically necessary. Medicare reimbursement for ambulance services is determined by the medical condition of the beneficiary at the time of transport. Medicare reimbursement for ambulance service is limited to emergency situations and to beneficiaries who are severely ill or disabled by injury or disease. The Medicare program is not meant to provide transportation for the general Medicare population who are able to safely travel by other means.

## **AUDIT SCOPE AND METHODOLOGY**

The objective of our review was to determine the allowability and reasonableness of ambulance claims submitted for Medicare reimbursement by ESAI. Our review of ambulance services provided by ESAI was made in accordance with generally accepted government auditing standards. The Carrier requested the review, and we issued our draft report to both the Carrier and ESAI.

The Carrier provided a disk containing paid ambulance claims. For the period July 1, 1999 to June 30, 2000, Medicare reimbursed ESAI \$226,199 for 59,617 ambulance services under seven procedures codes:

A0320	Ambulance service, BLS, non-emergency transport, supplies included, mileage billed separately.
A0322	Ambulance service, BLS, emergency transport, supplies included, mileage billed separately.
A0364	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed.
A0368	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed.
A0380	BLS mileage, per mile.
A0390	ALS mileage, per mile.
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation.

To accomplish our objective, we selected:

- ❶ A statistical sample of non-emergency BLS and ALS ambulance services and related mileage and supplies (procedure codes A0320, A0364, A0380, A0390 and A0422) billed for the same beneficiary on the same date of service. Medicare payments for these services totaled \$224,221. (See Appendix A and B for sample details) The sample contained 100 unique beneficiary dates of service totaling \$21,924 in paid claims.
- ❷ All BLS and ALS emergency ambulance services and related mileage and supplies (procedure codes A0322, A0368, A0390, and A0422). Medicare payments for these services totaled \$1,978.

For each sampled item, we examined the following documentation:

- Trip sheets prepared by the ambulance crew.
- Computerized claims information sheets submitted by ESAI to Medicare.
- Paid claims data provided by the Carrier.

In addition to the documentation we obtained at ESAI, we visited Shore Memorial Hospital (the hospital), and BMA Dialysis Clinic (the clinic) both located in Nassawadox, Virginia to review corroborating information or documentation supporting the medical necessity of the transport. We reviewed vehicle and crew requirements, physically observed three ambulances located on-site at ESAI's offices, and performed a visual inspection of the physical property and supplies to verify compliance with requirements for Emergency Medical Service (EMS) vehicles.

Our field work was conducted from October 2000 to January 2001 at the Carrier, ESAI, Shore Memorial Hospital, and BMA Dialysis Clinic.

## **RESULTS OF REVIEW**

We estimate that Medicare reimbursed ESAI at least \$110,417 for unallowable ambulance services. Based on the results of our sample, we believe that \$108,439 of the \$224,221 paid to ESAI during the period July 1, 1999 through June 30, 2000 was not allowable. Our review showed that most trip sheets were incomplete, or contained inaccurate information and could not support the reason for the transport. As a result, we used the hospital and the clinic records to confirm the necessity of the transport. Our estimate is based on:

- T 38 sampled items totaling \$7,781 that were not allowable because the transport was not medically necessary as the beneficiary was not bed confined nor in an emergency situation.
- T 22 sampled items totaling \$4,697 that were not allowable because they were for ALS services which ESAI was not equipped to provide. Also, 17 of these ALS transports were also not medically necessary.

We also determined that all 15 emergency ALS and 5 emergency BLS transports were not eligible for Medicare reimbursement. We questioned the entire \$1,978 reimbursed by Medicare because ESAI was not equipped to provide this level of service.

Non-Emergency BLS and ALS  
Ambulance Services

Trip Sheets were not Complete  
and did not Support the Transport

We found that trip sheets maintained by ESAI to support Medicare billings were incomplete. In March 1993 and December 1996, the Carrier issued Medicare Newsletters that indicated that trip sheets are the source documents used to substantiate ambulance services

billed to Medicare. The Newsletters indicated that, in many cases, the Carrier had found that trip sheets were incomplete and did not adequately support the billing. The December 1996 Newsletter listed various requirements to support Medicare billings. The Newsletter stated that the trip sheets must clearly and adequately reflect, among other things:

- Odometer readings--both beginning and ending mileage.
- Point of origin and destination.
- Diagnosis--the condition of the patient at the time of transport and the reason for the transport. If the beneficiary required ALS, medical necessity must be documented and personnel performing the services must be ALS certified, and
- Use of equipment that was medically indicated based on the patient's condition and diagnosis.

The Newsletter also stated that Medicare will not cover ambulance transportation when the patient is able to be transported by any other means. The provider must be able to substantiate that the services were rendered and medically necessary.

Our review of the trip sheets for the non-emergency sampled BLS and ALS ambulance services showed that the trip sheets did not always support the reason for the transport and lacked sufficient details to show what the condition of the beneficiary was at the time of transport. When information was recorded, it often was misleading as to the beneficiary's condition. For example, we found cases in which ESAI billed for transportation from a hospital back to the beneficiaries' place of residence. However, the trip sheets described the beneficiary's condition at the time of admission and not at the time of transport from the hospital.

We found, for example, that of the 100 trip sheets we reviewed:

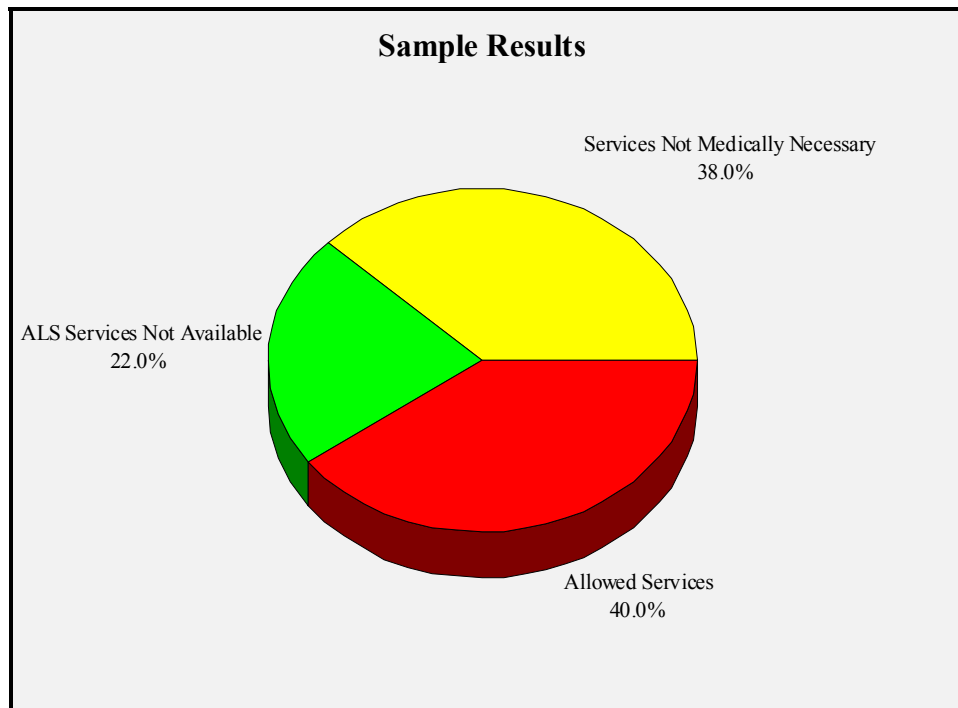
- 99 trip sheets did not indicate whether the beneficiary was bed confined.
- 98 trip sheets did not indicate whether or not a stretcher was needed to move the beneficiary.
- 95 trip sheets did not record the beneficiary's vital signs, and
- 92 trip sheets did not show the beginning and ending odometer readings.

For example, one trip sheet was blank and did not note any medical information about the transport. The trip sheet did not list the beneficiary's chief complaint and contained no medical entry of the condition at time of transport. In our opinion, ESAI's trip sheet could not support the transport for this beneficiary.

We also found that 55 trip sheets contained handwriting of another individual enhancing the notes and the reason for the transport. Enhancements included phrases such as "*complete assist*," "*extremely weak*," and "*no use of legs*." However, the trip sheets contained no indication of who made the enhancements or when they were done. These additions were made, after the transport was completed, by personnel other than the ambulance crew. The ESAI personnel stated that the enhancements were done in the office because the trip sheets did not contain all the information needed to generate a bill.

#### Sample Results

Because the trip sheets were incomplete and could not be relied upon, we obtained corroborating information from the hospital or the clinic's medical records. Our review identified deficiencies with most of the non-emergency BLS and ALS sampled items. The following chart shows that Medicare reimbursed ESAI for (1) services that were not medically necessary because the beneficiary was not bed confined, (2) ALS services that ESAI was not equipped to provide or (3) services that were allowable.



Services Must be Medically Necessary  
to be Reimbursed by Medicare

We questioned 38 sampled items totaling \$7,781 because the transport and related mileage and supplies were not medically necessary as the beneficiaries were not bed confined nor in an emergency situation. The Carrier's October 1996

Ambulance Billing Guide states that: Ambulance services are covered under such circumstances as: (1) accidents, injuries or acute illness requiring supine position on a stretcher; (2) combative behavior requiring restraints; (3) new or unstable bone fractures; and (4) any acute event that would create an unstable medical condition requiring special care and handling during transport. It further states that:

*"Medicare Part B defines bed confined as a condition which requires the beneficiary to spend 100% of their time in a reclining position". The statement "bed confined before and after the transport" is used to describe a beneficiary who is severely ill or injured, and would be unable to travel by any other means. The term "non-ambulatory" does not qualify a beneficiary for Medicare covered transportation. If a beneficiary can sit up, they do not qualify for Medicare covered transportation.*

*Note: Using "bed confined" on a claim as a medical reason for coverage when the beneficiary is not bed confined is considered falsification and could result in exclusion from the Medicare program and/or referral to the Office of the Inspector General for investigation."*

The following examples demonstrate the lack of medical necessity for the ambulance services billed by ESAI.

- ▶ Medicare paid ESAI \$74 for a transport and mileage for transporting a beneficiary from the hospital to a nursing home. The ESAI trip sheet stated that the patient was admitted with pneumonia and Alzheimer disease. The patient was not aware of his surroundings. We reviewed hospital records to verify the beneficiary's condition at the time of transport. According to the hospital's records, these statements support the beneficiary's condition when the beneficiary was admitted to the hospital, not the beneficiary's condition at the time of transport to the nursing home. Hospital records indicated that on the date of discharge, the beneficiary was *Alert today. No complaint of pain with movement. Stood up better today. Patient sitting up in chair, no distress, transferred via ambulance to nursing home no complaint offered.* We questioned these services. (Emphasis added)
- ▶ Medicare paid ESAI \$114 for transport and mileage for transporting a beneficiary from the hospital to a nursing home. The trip sheet stated that the patient was admitted with a major depression episode, a history of Parkinson's disease and chronic obstructive pulmonary disease. The patient was total assist and any movement caused shortness of breath. We reviewed the hospital medical record to verify the patient's condition at the time of transport. A physician consultant's note in the medical record, which was written 6 days prior to discharge stated: *He was up and ambulatory.* A Progress note written 4 days prior to discharge stated that the *Patient attending activity groups: social bingo, outside for walk and stress management.* We questioned these services. (Emphasis added)
- ▶ Medicare paid ESAI \$114 for transport and mileage for transporting a beneficiary from a nursing home to the hospital for outpatient surgery. The ESAI's trip sheet stated that the patient has a history of senile dementia. The patient is having eye cataract surgery. Our review of the hospital's medical records showed that the beneficiary could ambulate independently upon discharge after surgery. We disallowed these services because they did not meet medical necessity guidelines. Other means of transport could have been provided.

ESAI did not have Equipment  
to Provide ALS Transports

We questioned 22 sample items totaling \$4,697 because ESAI billed for ALS services which they were not equipped to provide. Also, 17 of the transports were also not medically necessary for same reasons cited above.

In October 1996, the Carrier provided guidelines on how to bill for ALS services in its Ambulance Billing Guide:



Ambulance suppliers must consider the vehicle, as well as the definitions of “emergency” and “specialized services,” when choosing the appropriate BLS or ALS ambulance transport codes for billing methods. Documentation should be available to support the code chosen for each transport. When reporting the ALS code, your documentation must reflect that an ALS vehicle was dispatched.

The Carrier guidelines also define specialized services as administration of intravenous (IV) services; use of anti-shock trousers; establishment of the patient’s airway; defibrillation of the heart; cardiac monitoring; or relief of pneumothorax conditions.

Our review found that ESAI had billed incorrectly for ALS transports and related services. We reviewed ambulance and licensing records for the 11 ESAI ambulances. These records showed that ESAI did not own or operate any EMS vehicles equipped to perform ALS services during our review period or at the time of our review. Consequently, we questioned all ALS non-emergency transports and their related services.

ESAI was Overpaid \$108,439

Based on the results of our statistical sample, we estimate with 95 percent confidence that at least \$108,439 of the \$224,221 paid to ESAI, during the period July 1, 1999 through June 30, 2000 were unallowable. The projection of our questioned cost is statistically valid and represents the lower limit of the 90 percent two-sided confidence interval.

#### Emergency ALS and BLS Transports

We questioned all 15 emergency ALS transports and 5 emergency BLS transports totaling \$1,978. We reviewed the 15 emergency ALS and 5 emergency BLS transports identified from the Carrier’s paid claims data. We questioned the 15 emergency ALS transports because ESAI was not equipped to provide this level of service.

Upon reviewing ESAI’s trip and computerized claims information sheets, we determined the emergency BLS transports did not occur. The five emergency BLS transports were incorrectly coded. The five were actually for oxygen, not a transport, but were not billed as oxygen by ESAI. According to ESAI’s owner, the Carrier told ESAI to bill for ALS services when providing oxygen to a beneficiary. However, ESAI did not furnish us with any written support for the statement. Additionally, ESAI billed the oxygen services as emergency BLS transports rather than as ALS services.

As a result, we questioned the 15 emergency ALS transports and the 5 emergency BLS transports totaling \$1,978.

Carrier Provided Education to ESAI

Despite numerous Carrier Newsletters and a Carrier audit of its billing practices, our review showed that ESAI continued to bill Medicare for unallowable ambulance services. In March 1993, December 1995, October 1996 and again in December 1996, the Carrier issued Medicare Newsletters and an Ambulance Billing Guide. The Newsletters and the Billing Guide provided guidance on Medicare coverage policies and billing procedures. The Carrier furnished copies of the Medicare Newsletters and the Billing Guide to ESAI and other ambulance organizations upon publication.

In November 1996, the Carrier issued a report to ESAI covering ambulance services billed to Medicare between December 1, 1994 and September 30, 1995. The Carrier determined that ESAI was overpaid \$38,108 and advised ESAI to review the December 1995 Medicare Newsletter which outlined that patients labeled as non ambulatory did not justify the transport. The Carrier reported that:

*“Our review was conducted on transports where the patients were being taken home from the hospital on the day of discharge. It is unusual for a patient to require ambulance transport on discharge from the hospital. Generally, a discharged patient can travel safely by other means. We found the statements, “bed confined”, “patient had no use of legs”, “patient could not walk” and “could not weight bear”, were being used on every trip sheet. The documentation however, provided in the trip sheet or patients records did not indicate that they were 100% bed confined. To be considered a covered transport for Medicare, the person must be bed confined 100% of the time. If the person could sit, stand, or walk with or without assistance they could be transported in another manner.”*

The ESAI appealed the audit findings and requested a Medicare Fair Hearing review. The Fair Hearing review was held in August 1997 at which time the Carrier’s findings were upheld. The hearing found that ESAI did not have compelling medical documentation to support the transports in question.

## CONCLUSIONS AND RECOMMENDATIONS

The findings in the Carrier’s audit are very similar to the findings identified in our review. Nevertheless, ESAI continued to bill for unallowable services. We determined that ESAI claimed and was reimbursed at least \$110,417 for unallowable ambulance services. We found that Medicare reimbursed ESAI for (1) services that were not medically necessary, and (2) ALS services that ESAI was not equipped to provide.

We are recommending that the Carrier:

1. Recover overpayments of \$110,417.

2. Provide ESAI increased education concerning the use of correct transportation codes and the requirement for beneficiaries to be bed confined in order to be eligible for ambulance services.
3. Consider placing ESAI on prepayment monitoring to ensure required support for the claim before payment is made.

### **ESAI'S RESPONSE AND OIG'S COMMENTS**

On July 7, 2001, ESAI responded to our draft report. The ESAI did not fully agree with our findings and recommendations and stated that only \$16,592 of our identified overpayments should be recovered based on the information provided in the response. The ESAI did not agree with the recommendation that the Carrier provide increased education because (i) ESAI believes that Carrier personnel do not have the level of understanding of the Medicare ambulance program to provide the training and (ii) ESAI has engaged a consulting firm to conduct training and establish a compliance program. Also, ESAI does not feel it is necessary to be placed on prepayment monitoring since (1) actions have already been taken to improve trip sheet documentation and (2) the Carrier will be unable to process claims in a timely manner which will affect ESAI's cash flow.

The ESAI commented on the three overpayment issues separately in their response. They provided comments for ALS, Medical Necessity and the Pricing findings. The ESAI stated that ALS codes were used in error and this was due in part to the confusing manner in which the Carrier implemented the coding changes in January 1995. The ESAI stated that they were unaware that the codes being used were incorrect. The confusion over the codes started in 1995 when providers had to choose a billing method. The ESAI chose "method 4" in order to bill separately for oxygen. They stated that the Carrier decided that "method 4" providers would use "method 2" codes if BLS services were provided, and "method 4" codes if ALS services were provided. The ESAI wanted to bill for oxygen separately on a BLS transport, however the Carrier denied the claims. According to ESAI, when they contacted the Carrier about the denials, the Carrier instructed them to use the ALS codes when billing oxygen separately, instead of explaining that oxygen was bundled into the BLS procedures. According to ESAI, this is what started the ALS billing error. The ALS codes were only used when oxygen was administered, as instructed to do by the Carrier. The ALS codes were not used to upcode services.

The ESAI stated that in the draft report medical necessity was based solely on the patient being "bed confined". However, the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Finance Administration) Program Memorandum AB-99-83 states "...bed-confined is not meant to be the sole criteria to be used in determining medical necessity. It is one factor to be considered when making medical necessity determination." Also, Section 2120.2 A of the Medicare Carriers Manual states "Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated". This clearly means that a patient does not have to be bed confined to meet the criteria for ambulance coverage, but rather that they have a medical condition that would place a patient's health in

jeopardy if transported by any other means. The ESAI included additional medical information to support the need for ambulance transportation for 45 of 51 claims sampled.

Regarding the Preferential Pricing contract, ESAI stated that they had provided us with the wrong contract. The prices listed on the contract were revised before it ever went into effect. A copy of the correct contract was provided with this response.

We reviewed the comments and materials provided with ESAI's response and have modified our report based on the additional information. We did not change the ALS findings because ESAI could not provide us with any documentation to support their position nor could they tell us who at the Carrier instructed them to use ALS codes to bill separately for oxygen services. According to ESAI, they have been billing for oxygen this way since 1995. The ESAI billed for both emergency and non-emergency ALS services. We saw nothing to indicate that these codes were only being used to bill for oxygen services separately. According to the Carrier, if ALS codes are used an ALS service was to be provided. The ESAI was not equipped to provide ALS services.

Our review to determine if ambulance services were medically necessary was based on the patient's condition, not just on the patient being bed confined. We reviewed each transport to see if the services are covered under such circumstances as: (1) accidents, injuries or acute illness requiring supine position on a stretcher; (2) combative behavior requiring restraints; (3) new or unstable bone fractures; and (4) any acute event that would create an unstable medical condition requiring special care and handling during transport. We then reviewed other supporting documentation to support the reason for the transport. We also reviewed the additional materials provided in ESAI's response and modified our finding accordingly.

We reviewed the pricing contract provided with ESAI's response and requested and obtained additional supporting documents. We now have reasonable assurance that the nursing home in question did not receive preferential rates for ambulance services. Therefore, we removed this finding from our report.

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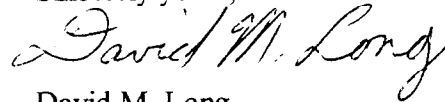
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Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HHS/OIG Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1994, as revised.)

To facilitate identification, please refer to Common Identification Number A-03-01-00001 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in cursive script that reads "David M. Long".

David M. Long  
Regional Inspector General  
for Audit Services

Direct Reply to HHS Action Official:

Patricia Harris, Acting Regional Administrator  
Centers for Medicare and Medicaid Services, Region III  
Public Ledger Building, Suite 216  
150 S. Independence Mall West  
Philadelphia, Pennsylvania 19106-3499

## **APPENDIX A**

### **SAMPLE METHODOLOGY**

#### **Objective:**

The objective of our review was to determine the allowability and reasonableness of ambulance claims submitted for Medicare reimbursement by ESAI.

#### **Population:**

The population consisted of the following Medicare Part B ambulance services billed by ESAI from July 1, 1999 to June 30, 2000: Services consisted of procedure codes A0320 BLS, non-emergency transport, and/or A0364 ALS, non-emergency transport, no specialized ALS services rendered, and any associated services (specifically procedure codes A0380 BLS mileage, A0390 ALS mileage and A0422 oxygen and oxygen supplies, life sustaining situation) billed for the same beneficiary on the same day.

#### **Sampling Unit:**

The sampling unit consisted of services billed for procedure codes A0320 and/or A0364 and any associated services (specifically procedure codes A0380, A0390, and A0422) billed for the same beneficiary on the same day (beneficiary date of service).

#### **Sample Design:**

A simple random sample was used for reporting the results of our review.

#### **Sample Size:**

A sample size of 100 units was used.

#### **Estimation Methodology:**

For all items that were unsupported, unallowable, or incorrectly coded we determined a dollar value. The dollar value was used to establish and project the dollar value of all unsupported, unallowable, or incorrect payments made to ESAI.

## APPENDIX B

### SAMPLE RESULTS AND PROJECTIONS

**Results of Sample:** The results of our review of 100 sample items (beneficiary dates of service) are as follows.

<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Non-Zero Errors</u>	<u>Value of Errors</u>
100	\$21,924	60	\$12,478

#### **Variable Projections**

Point Estimate	\$127,777
90% Confidence Interval	
Lower Limit	\$108,439
Upper Limit	\$147,114

EASTERN SHORE AMBULANCE SERVICE, INC.  
8426 SUGAR HILL LN  
P.O. BOX 6  
SANFORD, VA. 23426  
Phone Number: 757-824-5858 or 1-800-734-4161  
Fax. No. 757- 824-6246

July 7, 2001

Common Identification Number A-03-01-00001

David M. Long  
Regional Inspector General  
Office of Inspector General  
150 S. Independence Mall West Suite 316  
Philadelphia Pa. 19106-3499

Dear Mr. Long;

Enclosed is our response at E.S.A.I. to your draft letter of May 25, 2001, to Ms. Beth Brady of TrailBlazer Health Enterprises. We are commenting on each of the three-overpayment issues separately, as well as on your comments concerning the previous audit of November 1996. We hope that the enclosed information will be of assistance in reaching a satisfactory resolution of this audit.

#### ALS

In your draft there are several issues regarding ALS coding. The ALS codes were used in error, in part due to the confusing manner in which the carrier implemented the coding changes of January 1995. At that time Eastern Shore Ambulance was unaware that the codes we were using were incorrect. The confusion over the codes started in 1995 when providers had to choose a method of billing. There were two methods offered (method 2, which was an all-inclusive billing method and method 4, which allowed supplies to be billed separately). Eastern Shore Ambulance chose method 4 in order to bill separately for oxygen. However the carrier for Virginia decided, contrary to the H.C.F.A. instructions, to mix the method 2, and method 4 codes. The carrier decided that the method 4 providers would use method 2 codes if BLS services were provided, and method 4 codes if ALS services were provided. When we billed separately for oxygen on a BLS call the claim was denied. We called the carrier and they explained that we must use ALS codes when billing separately for oxygen, instead of explaining that the oxygen was bundled on BLS procedures. This is what started the ALS billing error. The ALS codes were only used when oxygen was administered, as we were instructed to do by the Carrier. ALS codes were never used for the purpose of up coding. This is evident by the apparent fact that the ALS code A0368 was billed at the same rate as the BLS code A0320. There is a difference of \$.48 between the BLS mileage and the ALS mileage, and \$13.60 for oxygen which we now know was bundled in the BLS base rate. We feel



that only \$8,461.47 of the suggested \$44,198.77 should be recovered do to the fact that the ALS and BLS base rates pay the same amount of money. In your draft letter it also states that 17 out of the 22 ALS claims were not medically necessary. We were not provided with a list of which 17 of the 22 claims were deemed not medically necessary, therefore providing additional documentation on these claims is impossible. We do however have Physicians Certification Statements stating the Wilson Smith (which is 12 of the 22 ALS claims) required ambulance transport and could not be transported by any other means. The Physicians Certification Statement for Wilson Smith is included with our response. We can also provide Physicians Certification Statements for the remaining 10 claims if we are provided with a list of the claims.

#### Medical Necessity

In your draft letter it states "... We questioned 51 sampled items totaling \$11,733.00 because the transport and related mileage and supplies were not medically necessary as the beneficiaries were not bed confined." It seems that in the draft medical necessity is being based solely on the patient being "bed confined". However in H.C.F.A. Program Memorandum AB-99-83, (Date November 1999) to intermediaries and carries it states "...bed-confined is not meant to be the sole criteria to be used in determining medical necessity, It is one factor to be considered when making medical necessity determinations. Additionally section 2120.2 A of the Medicare Carriers Manual states "...Medical necessity is established when the patients condition is such that use of any other method of transportation is contraindicated". If you have a local medical review policy (LMRP) that differs from this national definition established by H.C.F.A., you must revise your LMRP. The same Program Memorandum later states that "Medicare only covers ambulance services if they are furnished to a beneficiary whose condition is such that other means of transportation would be contraindicated." This clearly means that a patient does not have to be bed confined to meet the criteria for ambulance coverage, but rather that they have a medical condition that would place a patient's health in jeopardy if transported by any other means. I have included with our response medical information that supports the need for ambulance transport for 45 out of the 51 claims sampled. The medical information has been broke down by patient (see attachment A), for easy reference. The medical information came directly from Physicians Certification Statements also including with our response. We feel that with this information that \$102,277.29 of the \$110,407.53 suggested for recovery should be subtracted from \$168,220 that was recommended for recovery.

**Material Deleted - Report Modified**

## PREVIOUS AUDIT

In the your draft a previous audit is mentioned. And there is a letter from the carrier that states "It is unusual for a patient to require ambulance transport on discharges from the hospital...". This however is not true there are many cases that discharges require ambulance transport. The patient could have prior medical conditions that would justify ambulance transport such as prior stroke, dementia, combative, alzheimer's, or paralysis just to mention a few. These medical decisions are typically left to the patients Physician, as they well should be. Also in the your draft it states in a previous audit (Nov. 1996) that "The ESAI appealed the audit findings and requested a Medicare Fair Hearing review. The Hearing review was held in August 1997 at which time the Carrier's findings were upheld. The hearing found that ESAI did not have compelling medical documentation to support the transports in question.". This is an incomplete statement, over half of the \$38,108 was recovered when the case was appealed to an Administrative Law Judge. A letter from the attorney that tried the case is included with this written response (see attachment D).

## OUR CONCLUSIONS

Three recommendations were made to the carrier in the your draft, and we would like to comment on each as fallows.

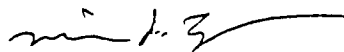
1. "Recover overpayments of \$168,220." *Our Response:* We feel that only \$16,591.71 should be recovered due to the information provided in this response.
2. "Provide ESAI education concerning the use of correct transportation codes and the requirements for beneficiaries to be bed confined in order to be eligible for ambulance services." *Our Response:* The problem with this recommendation is the level of understanding of the ambulance Medicare Program by the Carrier Personnel. Ambulance service is only aprox. 2% of the Medicare claims, additionally ambulance service claims are the only claims in Medicare that does not use ICD coding. Ambulance claims are based on a subjective inturpitation of "medical necessity" and "reasonableness" of the ambulance. We have had Trailblazer fax us a printout of their computer screen so that we could tell them what fields they should be looking in for information. Trailblazer's claim processors have also called us to get information about Medicare's rules and regulations. The carrier has also recently made several major mistakes in claims administration such as, implementing the new mileage code A0425, in direct violation of a HCFA directive, this error caused the denial of every claim for a period of 2 weeks for the entire state. Our emergency code A0429 was incorrectly priced, and we had to end up calling Texas's carrier to correct it because

no one at Trailblazer had the knowledge to access their own computer system. Texas's carrier corrected the price for the code, and instructed Trailblazer on April 30 to do a mass adjustment for the previously processed claims. We have not yet received a check for the mass adjustment that totals more than \$10,000.00. To correct these training problems ESAI has, at considerable expense, engaged a national Ambulance reimbursement consulting firm (EMS Consultants Ltd.) to train our personnel and set up Medicare compliance program.

3. "Place ESAI on prepayment monitoring to ensure required support for the claim before payment is made." *Our Response:* We feel this would not be necessary. First we have already had meetings with all of our employees concerning their inadequate run sheets documentation. We are also obtaining Physicians Certification Statements on every run. Additionally with the problems we have experienced with Trailblazer in the past we feel that they would be unable to process the claims in a timely manner necessary for us to stay in operation. It is our understanding that prepayment-monitoring works similar to Medicare Review, which means on average it, would take 3 months for a claim to be processed.

It is now, as it has always been our intent at ESAI to submit clean claims for Medicare processing. We realize that we have made some mistakes in the past, we have now taken all necessary steps to correct these mistakes, and assure that we submit only clean claims in the future. We are happy to repay any money that we owe the Medicare program due to any errors we may have made. This should be evidenced by the fact that we have voluntarily refunded thousands of dollars this year that Medicare has paid to us in error. We would like to thank the Office of the Inspector General for the opportunity to respond to their draft. If we could offer any assistance in the future concerning this audit please feel free to contact us.

Sincerely yours,



Dennis J. Taylor  
President

Eastern Shore Ambulance Service Inc.